



STATE OF TEXAS
Interagency
Eye Examination Report

Patient's Name _____ Date of Birth _____ Social Security No. _____
Address _____ City _____ State _____ Zip _____

Attention Eye Care Specialist

Address each item below.

★ *Your thoroughness in completing this report is essential
for this patient to receive appropriate services.* ★

Ocular History (e.g., previous eye diseases, injuries, or operations)

Age of onset _____ History _____

Visual Acuity

If the acuity can be measured, complete this box using Snellen acuities or Snellen equivalents or NIL, LP, HM, CF.

Without Glasses		With Best Correction	
Near	Distance	Near	Distance
R	R	R	R
L	L	L	L

If the acuity cannot be measured, check the most appropriate estimation.

☐ Legally Blind

☐ Not Legally Blind

Acuity with glare testing, if applicable: R _____ L _____

Muscle Function ☐ Normal ☐ Abnormal Describe _____

Intraocular Pressure Reading R _____ L _____

Visual Field Test

☐ There is no apparent visual field restriction.

☐ There is visual field restriction. Describe _____

☐ Yes ☐ No The visual field is restricted to 20 degrees or less.

Color Vision ☐ Normal ☐ Abnormal

Photophobia ☐ Yes ☐ No

Diagnosis (Primary cause of visual loss)

(OVER)

Prognosis☐ Permanent
☐ Progressive☐ Recurrent
☐ Communicable☐ Improving
☐ Can Be Improved**Treatment Recommended**☐ Glasses☐ Surgery☐ Patches (Schedule):☐ Hospitalization will be needed for approximately

R _____

_____ days.

L _____

Name of hospital _____

☐ Medication _____☐ Refer for other medical treatment/exam:

Name of anesthesiologist or group: _____

☐ Low Vision Evaluation☐ Other _____**Precautions or Suggestions (e.g., lighting conditions, activities to be avoided, etc.)****Scheduling**

Date of Next Appointment _____ Time _____

IMPORTANT

Check the most appropriate statement.

- ☐ This patient appears to have no vision.
- ☐ This patient has a serious visual loss after correction.
- ☐ This patient does not have a serious visual loss after correction.

Print or Type Name of Licensed Ophthalmologist or Optometrist

Signature of Licensed Ophthalmologist or Optometrist

Address

Date of Examination

City

State

Zip

()

Telephone Number

RETURN COMPLETED FORM TO:

Name

Address

Agency

City

State

Zip

This form should be used when an ophthalmological/optometric examination is needed for (the): Texas Commission for the Blind (TCB) • School Districts • Special Education Programs • Regional Education Service Centers (ESCs) • Early Childhood Programs (ECH) • Early Childhood Intervention Programs (ECI) • Texas School for the Blind and Visually Impaired (TSBVI) • Eye Screening FollowUp Examinations • Texas Department of Health (TDH) • Texas Department of Mental Health/Mental Retardation (TDMHMR).